



TRACIE  
HEALTHCARE EMERGENCY PREPAREDNESS  
INFORMATION GATEWAY

# JACKSONVILLE SHOOTING

## Fire Department Response to the Incident



*On Sunday, August 25th, an active shooter opened fire at competitors of a “Madden NFL 19” tournament in Jacksonville, FL. Dr. John Hick (ASPR TRACIE’s Senior Editor) interviewed Dr. Brad Elias, an Emergency Medical Specialist, to learn more about the Jacksonville Fire Department’s response to the incident.*

### ■ John Hick (JH)

**Brad, please tell us more about your role that day and describe the incident and your team’s response.**

### ■ Brad Elias (BE)

It was a Sunday afternoon, and our crews responded to the scene fairly quickly. I was getting reports of the number of casualties, so I knew by the time I would get downtown, it wouldn’t be helpful to have a physician respond to the scene.

We are a large agency comprised of almost 1,400 personnel, and we are a combined rescue-fire department. On that day, one of our rescue district chiefs took incident command and was one of the first units on scene.

This incident was a little different from what we’ve been training for. I’ve pushed the rescue task force (RTF) concept in the state of Florida, and we have been collaborating with the Jacksonville Sheriff’s Office, including in a full scale exercise involving RTFs. We’ve purchased a number of ballistic vests and helmets, stop-the-bleed bags, and other equipment. We have 16 district chiefs in the field with ballistic protection and stop the bleed bags. But on that day, interestingly, we had an engine/ladder crew doing some training near the incident. They witnessed people running and screaming through “The Landing” (the downtown entertainment district), and they were the first crew to respond, even before law enforcement—they were essentially operating in the hot zone. They quickly assessed the scene and called for ambulances, not knowing exactly what they had as far as casualties at first.

In this situation, we knew that people were coming out of the area, one or two at a time, and we called for one or two ambulances at a time. We are changing that now and sending a fairly aggressive package of initial response units. We can always recall the units if necessary.

We didn't really have a staging area—victims were running up to the fire and rescue personnel and being assessed and loaded on the next rescue unit. Unfortunately, there were three people dead on scene, and we transported eight patients to two of our trauma centers. They did a great job sending the more critical patients to the closer trauma center. We sent the more stable, extremity gunshot wound patients to the trauma center that is a bit farther away. While the Level 1 center could have probably handled the whole situation, we did not want to overwhelm the facility.

A number of patients were discharged the next or subsequent day. They did not need a lot of emergent operative services.

Regarding triage, we didn't use the Simple Triage and Rapid Treatment (START) method—we didn't use a real, true algorithm. We cleared the scene so quickly that there wasn't enough time to apply it. We basically received patients presenting to our ambulances, then we loaded and shipped them out. Again, because this happened on a Sunday, we were able to deploy more assets. Had we had more patients (or had this been a more catastrophic scenario with more casualties), we may have used START. It is part of our mass casualty incident (MCI) protocol.

I've been reviewing previous incidents (e.g., Pulse and Parkland) and none of them appear to have used START. When we were revising our MCI protocol, I talked with my division chiefs about this. We did some research and found that START is still in most metropolitan fire department MCI protocols. Practically speaking, it doesn't get used in a semi-manageable MCI like this was.

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*Since this incident, we have installed a response package in our computer-aided dispatch system that would send a sizable contingent of resources to an active shooter call.*

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■ JH

**Tell us about your department's demographics.**

■ BE

We have 58 stations with 49 rescues (ambulances). We are aiming to reach 55 in the next year. We are one of the five largest departments in the State of Florida. We handle 130,000 calls for service with approximately 92,000 transports yearly. What helps is that every apparatus we have is ALS certified; I think we're the largest fire department in the country that does that.

■ JH

**What's your policy on entering the hot zone?**

■ BE

This was part of our hot wash, and we are looking at our policy now. The guys did not even realize and were never told that the shooter was neutralized until a couple of hours afterwards. They were still operating under some assumption that he was still out there. While I'm a proponent of RTFs, there is concern with responding in a law enforcement-type environment. We need to have a balance. It is just as important for us to get in there to help people as it is to neutralize the threat. Our teams had good intentions—to save lives—that's what they do. And this case stands out because they were the first ones on the scene. We heard that a team of fire-rescue personnel did enter the building with a couple of patrolmen. So this was an escorted entry and resembled using a RTF, but it was not exactly the same.

One of our engine guys is also one of the SWAT medics. He was comfortable in that environment—it's good to have members of rescue formally integrated with law enforcement. We are now training every personnel how to wear the vest and helmet, and how to operate in the warm zones.

We originally purchased the vests with plates and helmets for the 16 district chiefs. We are now thinking of getting soft vests for every riding seat with the option of getting the plates later. In this situation, no one had a vest to put on, but had they been carrying the vests on the apparatus, they would have possibly donned them prior to entering the scene.

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*People often wonder if firefighters are equipped to enter the warm zone in an active shooter incident—I think Jacksonville answered that question. They charged in headlong and I am very proud of them.*

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■ JH

**What will your default ambulance assignment be to any future active shooter calls?**

■ BE

We will send 2 Engines, 4 Rescues, 1 Ladder, 1 Squad, 2 Suppression Chiefs, and 1 Rescue Chief to the scene.

■ JH

**Do you have a patient tracking system in place for MCIs?**

■ BE

We do have a plan to use a transportation officer and this would be done by clipboard and paper. In our MCI drills, in a more defined environment, this would work well. That said, in this specific incident, some people ran a couple of blocks down and requested assistance which added the dynamic of another possible scene. We had three dispatched incidents going when there was only one incident.

Everything comes down to training and collaboration. Cooperation with law enforcement was good. The paradigm culture shift change is happening. There was no hesitation; no one said “we need to wait for the all clear.” Everyone immersed themselves in the situation, got in to the scene, got the patients, and got them out.

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